LABORATORY SUBMISSION FORM FOR SARS TESTING

Send all specimens to: Washington State Department of Health Public Health Laboratories
1610 NE 150th Street, K 17-9, Shoreline, Washington 98155

Lab #

MANDATORY: Contact your local health jurisdiction (in King County, contact Public Health at 206-296-4774) or DOH Communicable Disease Epidemiology (877.539.4344) to determine if your patient meets the criteria for SARS-CoV testing at the Washington State Public Health Laboratories (PHL) before collecting and shipping specimens. Specimens will be processed following approval by your local health jurisdiction and DOH, after submission of a SARS investigation case report form. **Washington State Public Health Laboratories will not test specimens without prior approval.** *Specimens should be collected and packaged according to the guidelines outlined on the following websites: http://www.cdc.gov/ncidod/sars/specimen_collection_sars2.htm and http://www.cdc.gov/ncidod/sars/packingspecimens-sars.htm*

SARS-CoV testing at PHL requires documentation of informed patient consent, which should be retained with the patient's medical record. For more information and Centers for Disease Control and Prevention (CDC) consent forms, see: http://www.cdc.gov/ncidod/sars/lab/eia/index.htm and http://www.cdc.gov/ncidod/sars/lab/rtpcr/consent.htm.

Before collecting specimens, review infection control precautions for SARS at: http://www.cdc.gov/ncidod/sars/ic.htm

All specimens should be labeled with the patient's first and last name, the date collected, and type of specimen, and *must* be accompanied by a PHL submission form. Also include the signed consent form(s).

PATIENT INFORMATION	SUBMITTER INFORMATION
PATIENT NAME _____ (LAST NAME) (FIRST NAME)	Consent obtained from patient and enclosed ☐YES ☐NO
ADDRESS _____ (STREET)	Approved by Local County Health Jurisdiction ☐YES ☐NO
_____ (CITY) (STATE) (ZIP CODE) (COUNTY)	**MAIL RESULTS TO:**
DATE OF BIRTH _____/_____/_____ (MM/DD/YY)	AREA CODE/PHONE _____
DATE OF ONSET _____/_____/_____ (MM/DD/YY)	PHYSICIAN _____

SPECIMENS FOR THIS PATIENT BEING SENT IN THIS SHIPMENT:

I. SERUM *(1-2 milliliters)*

- ☐ A. Acute (≤ 7 days after onset) ..... Date of Collection _____/_____/_____
- ☐ B. Convalescent (>28 days after onset) ..... Date of Collection _____/_____/_____

II. UPPER RESPIRATORY TRACT

- ☐ A. Nasopharyngeal wash/aspirate ..... Date of Collection _____/_____/_____
- ☐ B. Nasopharyngeal/oropharyngeal swabs ..... Date of Collection _____/_____/_____

III. LOWER RESPIRATORY TRACT

- ☐ A. Sputum ..... Date of Collection _____/_____/_____
- ☐ B. BAL, tracheal aspirate, pleural fluid ..... Date of Collection _____/_____/_____

IV. STOOL *(10-50 milliliters)*

- ☐ Whole stool (7-21 days after onset) ..... Date of Collection _____/_____/_____

V. TISSUE *(post-mortem)*

- ☐ A. Fixed Tissue ..... Date of Collection _____/_____/_____
- ☐ B. Frozen Tissue ..... Date of Collection _____/_____/_____

(DO NOT WRITE BELOW THIS LINE)

	Specimen	Serology ELISA Result	Result Date	Initials	RT-PCR TaqMan Result	Result Date	Initials
1							
2							
3							
4							

INTERPRETATION/COMMENTS _____

UNIT HEAD(S) _____